Jasmine Irvin, Ph.D., HSPP
LICENSED PSYCHOLOGIST
www.drjasmineirvin.com
2003 Chapel Hill Rd. Durham, NC 27707
919.302.2308
jasmine.ti.irvin@gmail.com

REGISTRATION FORM

Today's Date: _____Date of Birth:_____
Your Name (legal and preferred): _____
Address: _____
_____
Phone numbers: Cell: _____Home: _____Work: _____

Voicemail OK? Y / N

Text message OK? Y / N

Email: _____ (please sign email release form)

Preferred form of communication: _____
Employed? Y / N Occupation: _____

Preferred gender identification pronouns:

Relationship status: ___ Single __ In committed relationship __ Married
__ Divorced __ Separated __ Widowed __Other:_____

Emergency Contact:

Name & Relationship to you:_____
Phone & Email: _____
Address: _____
_____

Insurance Status

I am out of network with insurance, which means you are responsible for paying the full fee at the time of service.

Please indicate if you would like me to file on your behalf for out of network reimbursement:

Y / N (If yes, I will copy your insurance card; if no, I will prepare billing statements at your request).

Medical/Mental Health History (use back of sheet if more space is needed)
Current medical issues:

Medications taken:

Are you currently in pain/do you experience chronic pain? If so, please describe:

Have you seen a mental health professional before? Y / N
If so, please list dates & providers: _____
_____

How did you hear about my practice? _____

Jasmine Irvin, Ph.D., HSPP
LICENSED PSYCHOLOGIST
www.drjasmineirvin.com
2003 Chapel Hill Road, Durham, NC 27707
919.302.2308
jasmine.ti.irvin@gmail.com

CLIENT AGREEMENT FOR SERVICES

Treatment Format

The initial meeting will be a consultation in order to best understand your current concerns, and how I might best be able to help you. We will discuss and agree upon the services needed and the course of treatment, and I will ask further questions about your history in subsequent sessions. The initial session is 60 minutes long, and subsequent sessions are either 45 or 60 minutes in length, per your request. Typically for ongoing therapy, I recommend weekly meetings to start. The length of treatment is individualized, and can vary from a few sessions to months or even years of treatment in order to meet the client's goals. Some clients choose to reduce session frequency over time, and such arrangements are acceptable and made collaboratively. It is always the client's right to end therapy at any time. I do recommend participation in a termination session to conclude the therapeutic relationship.

If you are interested in private mindfulness or yoga instruction, I will meet with you initially to discuss your needs, experience, and understanding of these practices, and we will collaborate on a program.

Appointments & Cancellations

Appointments can be made by contacting me by phone at 919.302.2308, or byemail jasmine.ti.irvin@gmail.com To cancel or reschedule an appointment, I ask that you contact me by phone, text, or email at least 24 hours in advance. If I do not receive such notice, you will be charged the full session fee (see fee amounts below) for the session missed.

Fees

Initial Therapy Evaluation/Consultation: $180 (60 min.)

Individual Therapy Sessions: $150 (45 min.) or $180 (60 min.)

Couple Therapy Sessions: $180 (60 min.) or $270 (90 min.)

Mindfulness or private yoga instruction $54 (30 min.) or $108 (60 min.)

Payment is expected at the time of service. Cash, check or credit card is accepted. Personal checks should be made payable to: Jasmine Irvin. For your convenience I can keep credit card information on file in an encrypted and confidential billing system, and can charge your card after each visit. If you incur a missed visit fee, I will also charge this to your card if you have given me permission to keep your card on file. If you would like to choose this option for billing, please initial here to acknowledge your agreement that your card may be charged in such instances _____.

A limited number of sliding scale slots are available and can be discussed upon request.

Insurance

I am out of network with insurance plans. This means that if you choose to use insurance, you will be responsible for the full fee at the time of service and then the insurance company may reimburse you directly for an established percentage of the fee based on your policy, once an out of network claim is filed. I am happy to help you file the insurance claim and have the reimbursement sent directly to you. I recommend that prior to your first session, you call to verify percentage reimbursement and whether you have a deductible that must be met before any reimbursement is distributed. Any questions about your individual insurance policy, and about reimbursement for services, should be directed to your insurance company. If you have requested that I submit insurance claims on your behalf, by signing this form you acknowledge

and consent to your information being released to your insurance company in order for such filling to be processed.

Legal Fees If you are involved in a lawsuit in which I am subpoenaed by any person or party to give deposition or courtroom testimony, you are responsible for reimbursing me at a rate of $250 per hour for time I spend on preparation, legal proceedings, and travel to and from those proceedings. If this occurs, I will send you a billing statement within 30 days.

Past Due Balances If a balance accrues for any reason, it is due within 14 days of the invoice date. Any amount not paid within 14 days will have a finance charge of 10% added for each two weeks of outstanding balance. A collection agency will be notified if the bill has not been paid within 30 days. If an attorney must be hired, all fees will be charged to you as well.

Records

All client information and records of communication are stored electronically through a password protected system and all paper copies of information are kept in a locked file cabinet. _____

Please see HIPAA Privacy Notice for further information about the protection of client information and confidentiality.

Consent to Treatment

By signing below, you are indicating that Jasmine Irvin, Ph.D. is authorized to provide you with psychological assessment, therapy, or services that are considered necessary and advisable. You have read and understood this statement and you had an opportunity to ask questions about and clarify any information unclear to you. You are giving consent to maintain communication by phone, email and/or mail and that you will notify me of any changes to your contact information.

By my signature, I verify the accuracy of this document and

acknowledge my commitment to maintain its specifications.

_____ _____

Client Signature Date

_____ _____

Therapist Signature Date

Fact Sheet and Patient Request for Email Communications

You must complete this form and return it to me before I can communicate with you via email.

This Fact Sheet informs you about the risks of communicating with me via email and how I may use and disclose email you send me. Communications over the Internet and / or using the email system may not be encrypted and may not be secure. There is no assurance of confidentiality when communicating via email.

PLEASE READ THIS INFORMATION CAREFULLY

Email communications are two-way communications. However, responses and replies to emails sent to or received by either you or your health care provider may be hours or days apart. This means that there could be a delay in receiving treatment for an acute condition. If you have an urgent or an emergency situation, you should not ever rely on email to request assistance or to describe the urgent or emergency situation. Instead, you should act as though email is not available to you and seek immediate medical attention by calling 911 if necessary.

Email messages on your computer, laptop, or other device have inherent privacy risks especially when your email access is provided through your employer or when access to your email messages is not encrypted. Unencrypted email provides as much privacy as a postcard. You should not communicate any information with your health care provider that you would not want to be included on a postcard that is going to go through the mail.

Email is sent at the touch of a button. Once sent, an email message cannot be recalled or cancelled. Errors in transmission, regardless of the sender's caution, can occur. You can help minimize this risk by using only the email address that you provide to me to forward or to process and respond to your email.

Neither you nor the person reading your email can see the facial expressions or gestures or hear the voice of the sender. Email can be misinterpreted. At your health care provider's discretion, your email message and any and all responses to them may become part of your medical record.

In some circumstances you might sign a release of information consenting for me with communicate with another provider or person about our work together. If you sign an authorization form for me to communicate with another individual about our work and that authorization form does not include specific language prohibiting the sharing of information received by email than any and all email correspondence is subject to being shared with such individuals.

If there were a breach of your protected health information (PHI) by me, you have the right to be notified of the breach. A breach of PHI is acquisition, access, use, or disclosure of your PHI in violation of HIPAA Privacy Rules. If a breach were to occur, you have a right to be notified and I would notify you. In addition, I would conduct an investigation and risk assessment of the breach to determine how to make necessary adjustments and to prevent recurrences of breaches. It is recommended that you send a test email before corresponding via email.

I understand and agree to the following:

I certify the email address provided on this request is accurate, and that I accept full responsibility for messages sent to or from this address.

I have received a copy of the F act Sheet and Patient Request for Email Communications form, and I have read and understand it.

I understand and acknowledge that communications over the Internet and/or using the email system may not be encrypted and may not be secure; that there is no assurance of confidentiality of information when communicated via email.

I understand that all email communications may be forwarded or shared with any person for whom I have signed a release of information form, unless I have explicitly requested that emails not be shared with the person and this request was documented on the release of information form that I signed.

I agree to hold Jasmine Irvin and individuals associated with her harmless from any and all claims and liabilities arising from or related to this request to communicate via email.

_____ **Printed Full Name**

_____ _____ **Signature/Date**

Email address I wish to use (Please print VERY clearly):

_____

Jasmine Irvin, Ph.D., HSPP
LICENSED PSYCHOLOGIST
www.drjasmineirvin.com

2003 Chapel Hill Rd.
Durham, NC 27707
919.302.2308
jasmine.ti.irvin@gmail.com

HIPAA Privacy Notice

Policies and Practices to Protect the Privacy of your Health Information

IN COMPLIANCE WITH THE HEALTH INFORMATION PORTABILITY AND ACCOUNTABILITY ACT (HIPAA), THIS NOTICE DESCRIBES HOW PSYCHOLOGICAL AND MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

I. Uses and Disclosures for Treatment, Payment, and Health Care Operations

Jasmine Irvin, Ph.D. may use or disclose your Protected Health Information (PHI), for treatment, payment, and health care operations purposes with your written authorization.

Definitions for clarification of terms:

Lavender Avenue Therapeutics– The named private practice. Unless otherwise specified, the name Jasmine Irvin Ph.D., or "I," refers to the above named psychologist owner.

PHI – Information in your health record that could identify you.

Treatment – When I provide, coordinate, or manage your health care and other services related to your health care. An example of treatment would be when I consult with another health care provider about your care.

Payment – When I help you obtain reimbursement for your healthcare. An example of this would be when I disclose your PHI to your health insurer to help you obtain reimbursement for your health care.

Health Care Operations – Activities that relate to the performance and operation of this practice. Examples of this are quality assessment and improvement activities, business-related matters such as audits and administrative services, and case management and care coordination.

Use – Applies to activities within my practice such as sharing, employing, applying, utilizing, examining, and analyzing information that identifies you. This applies to Jasmine Irvin, Ph.D., for treatment or assessment and any office assistant who may be employed to assist with scoring instruments or record keeping.

Disclosure – Applies to activities outside my practice, such as releasing, transferring, or providing access to information about you to other parties.

Authorization – Your written permission to disclose confidential mental health information. All authorizations to disclose must be done on a specific form.

II. Other Uses and Disclosures Requiring Authorization

Jasmine Irvin, Ph.D. may use or disclose PHI for purposes outside of treatment, payment, or health care

operations when your appropriate authorization is obtained. In those instances when I am asked for information for purposes outside of treatment, payment, or health care operations, I will obtain authorization from you before releasing this information.

I will also need to obtain additional authorization before releasing your psychotherapy notes. Psychotherapy notes are different from and not included in PHI, and include notes that have been made about the content of an individual, group, couple, or family therapy session.

III. Revocation of Authorization
You may revoke all or any authorizations of PHI and/or psychotherapy notes at any time, provided each revocation is in writing. You may not revoke and authorization to the extent that 1) I have relied on that authorization; or 2) if the authorization was obtained as a condition of obtaining insurance coverage, law provides the insurer the right to contest the claim under the policy.

IV. Uses and Disclosures without Authorization
Under North Carolina law, Jasmine Irvin, Ph.D. may use or disclose PHI without your consent or authorization under any of the following circumstances:

- Child Abuse – If you give me information that leads me to suspect child abuse, neglect, or death due to maltreatment of any child, I must report such information to the county Department of Social Services. If asked by the Director of Social Services to turn over information from your records relevant to a child protective services investigation, I must do so.

- Adult and Domestic Abuse – If you provide me with information that leads to reasonable belief that any disabled adult is in need of protective services because of abuse or neglect by another person, I must immediately report this to the Department of Social Services.

- Health Oversight Activities – The North Carolina Psychology Board and other professional boards have the power, when necessary, to subpoena relevant records should I be the focus of an inquiry.

- Judicial and Administrative Proceedings – If you are involved in a court proceeding and a request is made for information about the professional services I provided you and/or the records thereof, such information is privileged under North Carolina law, and I will not release such information without the written authorization of you or your legally appointed representative, or a court order. Be advised, if a court order requires that your records be released, under law I must release them, even without your written consent or authorization. The privilege does not apply when you are being evaluated for a third party or where the evaluation is court ordered. You will be informed in advance if this is the case.

- Serious Threat to Health or Safety – If I believe disclosure of PHI is necessary to protect you or another individual from a substantial risk of imminent and serious physical injury, I will disclose the PHI to the appropriate individuals, which may include but is not limited to family members, police, or the individual at risk of harm.

- Worker's Compensation – If you file a worker's compensation claim, I am required by law to provide your mental health information relevant to the claim to your employer and the North Carolina Industrial Commission.

V. Patient's Rights and Psychologist's Duties
Patient's Rights:
Right to Request Restrictions – You have the right to request restrictions on certain uses and disclosures of protected health information. However, I am not required to agree to a restriction you request.

Right to Receive Confidential Communications by Alternative Means and at Alternative Locations – You have the right to request and receive confidential communications of PHI by alternative means and at alternative locations. For example, you may not want a family member to know you are seeing a psychologist. At your request, I will send your bills to another address.

Right to Inspect and Copy – You have a right to inspect and/or obtain a copy of PHI in my mental health and billing records used to make decisions about you, for as long as the PHI is maintained in the record. I may deny your access to PHI under certain circumstances, but in some cases you may have this decision reviewed. You may be denied access to psychotherapy notes if I believe that a limitation of access is necessary to protect you from a substantial risk of imminent psychological impairment or to protect you or another individual from a substantial risk of imminent and serious physical injury. I shall notify you or your representatives if I do not grant complete access. On your request, I will discuss with you the details of the request and/or denial process.

Right to Amend – You have the right to request an amendment of PHI for as long as the PHI is maintained in the record. I may deny your request. On your request, I will discuss with you the details of the amendment process.

Right to be notified if there is a breach of your unsecured PHI: If there were a breach of your PHI, you have the right to be notified of the breach. A breach of PHI is acquisition, access, use, or disclosure of your PHI in violation of HIPAA Privacy Rules. If a breach were to occur, you have a right to be notified and I would notify you. In addition, I would conduct an investigation and risk assessment of the breach to determine how to make necessary adjustments and to prevent recurrences of breaches.

Right to restrict disclosures when you pay out of pocket for your therapeutic services: if you pay out of pocket for your therapeutic services you have the right to restrict disclosure of your PHI to your health insurance plan/carrier. This provision may be necessary were the health insurance plan to dispute reimbursing you for services. Please know that in any correspondence about such matters with insurance, I provide the minimal necessary information and will seek to obtain your permission prior to communicating with the health insurance plan (even though this HIPAA regulation states that I do not have to obtain permission).

Right to an Accounting – You generally have the right to receive an accounting of disclosures of PHI. Upon your request, I will discuss with you the details of the accounting process.

Right to a Paper Copy – You have the right to obtain a paper copy of this notice from me upon request, even if you have agreed to receive the notice electronically.

Psychologist's Duties:
I am required by law to maintain the privacy of PHI and to provide you with a notice of my legal duties and privacy practices with respect to PHI (this document).

I reserve the right to change the privacy policies and practices described in this notice. Unless I notify you of such changes, however, I am required to abide by the terms currently in effect (as described in this document).

I reserve the right to change the terms of this notice and to make the new notice provisions effective for all PHI that I maintain. If this occurs, I will provide you with a revised notice in writing either by mail or in person during a regularly scheduled appointment.

VI. Questions and Complaints
If you have questions about this notice, disagree with a decision we make about access to your records, or have concerns about your privacy rights, you may contact Jasmine Irvin, Ph.D. at Lavender Avenue Therapeutics directly by phone at (919) 302-2308 or in writing at 210 W. Lavender Ave. Durham, NC 27704.

If you believe that your privacy rights have been violated and wish to file a complaint with my office, you may send your written complaint to the address provided above.

You may also send a written complaint to the Secretary of the U.S. Department of Health and Human Services.

You have specific rights under the Privacy Rule. I will not retaliate against you for exercising your right to file a complaint.

VII. Effective Date, Restrictions and Changes to Privacy Policy
This notice will go into effect on January 1, 2015.

___ I received a copy of the HIPAA Privacy Notice from Jasmine Irvin, PhD.

___ I was offered but declined a copy of the HIPAA Privacy Notice

_____
Printed Name

_____ _____
Signature of client Relationship to client
(or Parent/Guardian if client is under 18 years old)

_____
Date